South Carolina Department of Health and Human Services
Consolidated Application for Healthy Connections (Medicaid)

This application is used to apply for Medicaid programs at the South Carolina Department of Health and Human Services (SCDHHS). Please answer all questions as completely as possible as they apply to you or the persons for whom you are applying. If you need help filling out this application, you can call or go to your local SCDHHS office and someone will be glad to help you.

You can find a list of Medicaid offices in South Carolina at www.scdhhs.gov or call 1-888-549-0820 (this is a free call) and someone will help you find your local office.

Federal law requires that anyone who applies for Medicaid for themselves must tell us about their citizenship or immigration status and provide or apply for a Social Security Number (SSN). We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. SSNs provided will be used to help the State agency determine eligibility. Each non-citizen applying for full Medicaid benefits must provide United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94. Anyone applying as a non-citizen for emergency services only is not required to provide USCIS documents or a SSN.

Some family members of applicants may choose not to apply for Medicaid. In that case, they do not have to provide a SSN or citizenship or immigration status but will be required to provide information about their income and assets. Benefits to applicants will not be delayed or denied just because some family members do not wish to apply. Even though a person not applying for Medicaid is not required to provide a SSN, it is helpful for us to have this number as we gather the information we need to make a decision. We use SSN to help us check identity, verify eligibility and prevent fraud. We exchange information with other agencies according to Federal rules and to manage our programs.

How do I apply for benefits?

- You must fill out this application using Black or Blue ink or by Typing your answers
- Attach extra sheets if you need more space to answer any of the questions
- Take or mail your application to your local Medicaid eligibility office
- To be valid, the application must have your name, contact information and be signed
- If we do not have everything we need, we will mail you a list of what you need to send us
- When we have everything we need, a decision will be made about your Medicaid eligibility. You should receive a letter within 45 days from the date we receive your application to tell you if you are eligible. If you need a disability determination, it may take up to 90 days
- Immediately report any change in income or other information on your application to your local Medicaid office
- We may share this information with other Federal and state agencies as we gather what we need to make a decision

Date Application Received by DHHS: _____

1. Tell us who is the head of the household and how we can get in touch.

Name (First, Middle Initial, Last)	**County** (Where you live)	**May we contact by e-mail?** ☐ **Yes** ☐ **No** **E-Mail Address:**
Home or Street Address (include apartment or lot number) **City** **State** **Zip Code**		**What is your preferred language?**
Mailing Address (If different from where you live) **City** **State** **Zip Code**		**Spoken** ☐ English ☐ Spanish ☐ Other:
Phone Numbers **Home:** **Work:** **Cell:**		**Written** ☐ English ☐ Spanish ☐ Other:

2. List yourself and everyone who lives in your home, even if you do not want Medicaid for them. If you are applying for someone who does not live with you (such as someone who needs nursing home or long term care), just tell us about that person and their spouse and dependents.

This information is Optional for:
- Anyone not applying for Medicaid coverage;
- A non-citizen applying for Emergency Services Only

	Name	Relationship to the Head of Household * (Use Relationship Codes shown below)	Marital Status Single, Married, Divorced, Widowed, Separated	Date of Birth	Sex	Is this person applying for Medicaid?	Social Security Number	Race ** (Race codes shown below)	Is this person a US citizen?
1.	Head of Household				☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
2.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
3.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
4.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
5.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
6.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
7.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
8.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
9.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No
10.					☐ Male ☐ Female	☐ Yes ☐ No			☐ Yes ☐ No

*** Relationship Codes:** **SP** Spouse **BF/GF** Boyfriend/Girlfriend **NR** Not Related **OTH** Other **CH** Child (Natural or Adopted) **SC** Step-Child **GC** Grandchild **NE** Niece/Nephew

**** Race Codes:** **01** White/Caucasian **02** Black/African American **03** Multi Race **04** Federally Recognized Native American *(Requires Verification)* **05** Other Native American **06** Alaska Native **07** Asian **08** Other/Unknown **09** Native Hawaiian/Pacific Islander **10** Hispanic

3. Are you pregnant or applying for someone who is pregnant? ☐ Yes ☐ No

Name of Pregnant Woman	Expected Due Date	Number of Babies Expected

If someone is expecting more than one baby (such as twins or triplets), you must give us proof from the doctor or other medical professional

4. Are you blind or disabled or applying for someone who is blind or disabled? ☐ Yes ☐ No

Name of Blind or Disabled Person	Is this Person Receiving or Applying for Social Security or SSI	
	☐ Receiving Social Security or SSI	☐ Applying for Social Security or SSI
	☐ Receiving Social Security or SSI	☐ Applying for Social Security or SSI

5. If any child does not have both parents living in the home with them, please list below.

Child's Name	Absent Mother's Name	Absent Father's Name

6. Are you or someone you are applying for going to school right now? ☐ Yes ☐ No
If **Yes,** list everyone age 16 or older who is going to school, the name of the school and what grade:

_____

_____

7. Do you or someone you are applying for need nursing home services, either in a nursing home or at home? ☐ Yes ☐ No
If yes, who: _____ ☐ Nursing Home ☐ Services at Home

8. Do you or someone you are applying for need to go into a Residential Care Facility/Boarding Home? ☐ Yes ☐ No
If yes, who: _____

9. Are you or someone you are applying for currently in a Hospital, Nursing Home, or Residential Care Facility? ☐ Yes ☐ No
If yes, who: _____ Date Entered: _____ Where: _____

10. Have you or someone you are applying for been diagnosed with and requires treatment for any of the following? ☐ Yes ☐ No
☐ Breast Cancer ☐ Cervical Cancer ☐ Atypical Breast Hyperplasia ☐ Precancerous Cervical Lesions (CIN 2/3)
If Yes, tell us who: _____

11. Have you or someone you are applying for received medical services in the past three months? ☐ Yes ☐ No

Person(s) Receiving Medical Services	Months Services Received

You will have to give us information about income and assets for each month to see if the person may be Medicaid eligible

Family Planning is a limited benefits program that helps with Family Planning Services only. Family Planning services include birth control methods; permanent sterilization procedures (vasectomy and tubal ligation); and family planning related lab work, examinations, limited prescriptions, office visits, and counseling. If someone is not eligible for regular Medicaid benefits, we can look to see if that person is eligible for Family Planning.

If someone applying on this application is not eligible for regular Medicaid benefits, do you want us to see if they are eligible for Family Planning?

☐ This is an application for Family Planning only. Look at Family Planning for everyone I have checked as applying. Do not look at any other Medicaid category.

☐ Yes, look at Family Planning for the following people if they are not eligible for Medicaid:

_____

_____

☐ No, I do not want Family Planning to be considered for anyone shown on this application, even if they are not eligible for Medicaid

If you do not answer this question, we will NOT look at the Family Planning program for anyone on the application

12. Does anyone in the home pay child support for a child outside your home? ☐ Yes ☐ No

Who is paying child support?	How much is paid?	How often is this paid?	If Court ordered, give the State, County and Case Number

13. Do you pay someone to take care of a child under the age of 12 and/or dependent adult while you work or attend school? ☐ Yes ☐ No

Name of Child or Dependent Adult	Name of Provider or Daycare Center and Address	Phone Number	How much do you pay?	How often do you pay?	ABC Voucher?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

14. Did you or someone you are applying for retire from the military, have a service related disability, OR are the spouse or dependent of someone who has retired from the military or has a service related disability? ☐ Yes ☐ No

If Yes, tell us who? _____

15. Tell us about the income of each family member in the home.

☐ **NO ONE IN THE HOME HAS ANY INCOME**
If checked, explain how you pay your bills

Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks.

Income from Employment	Income from Employment
Name of person working _____	Name of person working _____
Employer's Name _____	Employer's Name _____
Employer's Address _____	Employer's Address _____
_____	_____
_____	_____
Employer's Phone Number (including area code) _____	Employer's Phone Number (including area code) _____
Gross amount earned per pay period before taxes? $_____	Gross amount earned per pay period before taxes? $_____
How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
When is it paid?	When is it paid?

Is anyone self-employed? ..... ☐ **Yes** ☐ **No**

If yes, please send copies of all the Personal and Business Federal income tax forms most recently filed with the IRS. Include all forms and schedules.

Please tell us who is self employed and the name of the business:

Do you or anyone in your home receive, or have applied for, any other income? ..... ☐ **Yes** ☐ **No**

If Yes, check all boxes that apply and complete the table below

Name each child who gets Child Support and the amount paid for the child. If court ordered, include the State, County, and Case Number in the comments below.

☐ Social Security benefits (RSDI)
☐ Supplemental Security Income (SSI)
☐ Child Support
☐ Disability benefits
☐ Pension/retirement benefits
☐ Unemployment benefits
☐ Rental Income
☐ Veterans Administration (VA) benefits
☐ Military allotments
☐ Money from friends or relatives
☐ Alimony
☐ Worker's Compensation
☐ Federal Retirement (Civil Service, FERS)
☐ Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement)
☐ Other: _____

Person receiving/expecting money	Income source/type	How often received	Amount received	Comments

16. Has anyone in the home stopped working within the past year? ☐ **Yes** ☐ **No** If YES, tell us who was working, where, and when the job ended.

_____

Please answer question 17 ONLY if you are pregnant or applying for children in the home.

17. Does the equity value of all your assets add up to more than $30,000? Do not count the value of the home you live in or up to $20,000 of equity value per vehicle for each licensed driver.

☐ **Yes, my assets are over $30,000** ☐ **No, my assets are less than $30,000**

Assets are things that you own, such as cars, boats, trailers, non-homestead property, checking and savings accounts, cash, and CDs. Equity value is how much something is worth minus any money owed on it. (For example, a vehicle that is valued at $5000, and $2000 is still owed on it, has an equity value of $3000.)

Please answer questions 18 and 19 ONLY if you are applying for a disabled child OR if you or your spouse are blind, disabled, or aged 65 or older AND are applying for Medicaid

18. Look at the list below. Check the box for anything on the list that you, your spouse, or other person in your home may own. For anything that you check, please tell us about it on the lines below.

When we start working on your application, you may be asked to send in proof of the assets you tell us about.

☐ Bank Checking Account	☐ Bank Savings Account	☐ Certificate of Deposit	☐ Trust Fund or Trust Account
☐ Safe Deposit Box (Include a list of the contents)	☐ Car, Truck, Van	☐ Annuity (If Yes, provide a copy)	☐ Cash on Hand
☐ Stocks, Bonds, or Mutual Funds	☐ Motorcycle, Boat, Camper	☐ Farm Machinery or Business Equipment	☐ Life Insurance
☐ 401K, IRA or other Retirement Account	☐ Pre Need Burial Contract	☐ Cemetery Burial Space	☐ Money Set Aside for Burial
☐ DirectExpress Debit Card for SSA, SSI or other benefits	☐ Other (Please be specific):		

Owned By	Tell us about the asset Include the location, such as the name of bank or funeral home, and any account numbers or other information used to identify the asset	Current Value or Balance

19. Do you or your spouse own any property? *If you answer **YES** to any of the following questions, please tell us about the property on the next page.*

Home (house, buildings and land where you live)	☐ Yes	☐ No	Other House or Building (not your home)	☐ Yes	☐ No
Land (not connected to the home)	☐ Yes	☐ No	Vacation Home or Time Share Property	☐ Yes	☐ No

What is the address/location of the property? *List Home Property First*	What is the address/location of the property?
_____	_____
_____	_____
_____	_____
Owner's Name: _____	**Owner's Name:** _____
Is this your Home Property or Primary Residence where you currently live or where you want to return to live if you are living somewhere else? ☐ Yes ☐ No	

20. Does anyone have private health insurance, Medicaid from another state (other than SC), or Medicare? ..... ☐ **Yes** ☐ **No**

Policy Holder	List everyone covered by the insurance	Name of Insurance Company	Policy Number or Medicare Number

Please include a copy of the front and back of all health insurance cards

PLEASE READ THE FOLLOWING RIGHTS AND RESPONSIBILITIES AND SIGN THE APPLICATION ON PAGE 9

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Medicaid can have free health checkups and other services under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Healthy Connections Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Healthy Connections Card(s).
   a. I know that, in accordance with the federal rules governing the Healthy Connections Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
   b. I know that, in accordance with the federal rules governing the Healthy Connections Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and

Rights and Responsibilities

me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medical Assistance programs, and the TANF and Food Stamp agency (Department of Social Services (DSS), in this state). Immigration status of applicants will be verified with the Department of Homeland Security (DHS).

c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

3. I know that my Social Security Number, which I am required to provide for persons applying to receive health coverage, under §1137(a) (1) of the Social Security Act [42 U.S.C. 1320b-7(a) (1)], may be used or released to verify eligibility and in the administration of the Healthy Connections Program as indicated in item 2.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

5. I know that the Healthy Connections Program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Healthy Connections coverage.

7. I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

   If eligibility is for my child(ren) only, I am not required to report any changes in my situation, except for change of address. If I report any other changes in my situation, it will not affect their eligibility for benefits until the next scheduled review.

8. I know that I may request a hearing if I believe an error has been made in processing my application.

9. I know that DHHS must be named as a primary remainder beneficiary for any annuity owned by a Medicaid beneficiary receiving long term care services, regardless of irrevocability or other treatment of the annuity.

10. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
    - A person of any age who was a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
    - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

    I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

Rights and Responsibilities

11. I authorize the release of any information necessary to establish my family's eligibility. I authorize the copying of this signature page to be used as a release form to verify information. It shall remain valid and in force until:
    - Revoked by me in writing;
    - My application has been denied; or
    - My case has been closed.

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Healthy Connections beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a $25 fee. I want to voluntarily apply for these services. ☐ Yes ☐ No

PLEASE CALL YOUR LOCAL ELIGIBILITY OFFICE IF YOU HAVE ANY QUESTIONS ABOUT THE RIGHTS AND RESPONSIBILITIES

By signing this application:

- I state that I have read the Rights and Responsibilities or they have been read to me.
- I certify under penalty of perjury that the information I have provided to DHHS is true and accurate to the best of my knowledge.

Applicant's Signature: _____ Date: _____

If the applicant signs with an "X", the signature must have two witnesses

Witness 1: _____ Date: _____

Witness 2: _____ Date: _____

Do you want to name someone as your Authorized Representative for your case? ..... ☐ Yes ☐ No

If you name an Authorized Representative, there is a form for you to sign to give us permission to talk to this person about your case. We will also be able to send all letters and notices to this person. Please check if this person has ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship for you and include a copy if possible.

Please tell us about the person you would like to be your Authorized Representative:

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

_____ Alternate Phone Number: _____

Please sign if you have filled out this application for someone:

Signature: _____ Date: _____

I helped the applicant complete this application or I am applying for someone who is unable to act on his/her own behalf. I understand that anyone helping an individual to receive benefits dishonestly is subject to criminal penalties. I certify that the answers on this form:

☐ Were provided by the applicant/beneficiary ☐ Are what I personally know about him or her.